New Client Guide

When starting a new client you will either be remote connecting in to use their software, logging in to their web based software or setting up an account for them in Practice Mate.

If starting a new client in Practice Mate, refer to the ***New Client Checklist (Practice Mate)*** *for how to set the new client up in Practice Mate. Then proceed with this guide.*

If starting a new client via remoting into their locally based software, refer to the ***Setting Up a Secure Remote Connection*** *guide and then proceed with this guide.*

If starting a new client using their web based software, proceed with this guide.

Starting a client

1. Get the contracts signed and sent back.
2. Get the set up fee collected.
3. Get the New Client Information sheet filled out.
4. Get their software login information.
5. Get their clearinghouse login information.
6. Get from them, if not already done, what they consider to be their pressing issues and their needed and wanted items.
7. Log into their software and clearing house to ensure the login works and you have no issues. (Resolve issues if they arise.)
8. Establish with them who will enter the following information:
    - Patient demographic information
    - Patient insurance information (the biller doing this is recommended)
    - Diagnosis codes
    - Charge information

They may already be entering all this information in the office. If so and if it's working for them, there is no need to change it.

9. Inform them how they are to send you the information that you need on a regular basis (insurance cards, EOBs, etc.)
10. Contact tech support or the software training materials and orient yourself with the following:
    - Entering patient demographics
    - Entering insurance information

- Entering diagnosis codes
- Entering Insurance companies
- Entering insurance information for a patient
- Entering charges
- Reviewing claims to send
- Sending claims
- Correcting claim errors
- Rebilling claims

11. Establish where you pick up in the billing cycle and begin doing so. Contact tech support for training and help as needed.

    NOTE: the first and most important product you need to get out are the claims going out.

Entering Demographics:

Enter the following information in the patient file:

1.) Patient name
2.) Patient address
3.) Date of birth

Entering Insurance information:

Each software company stores this information in their own way. Contact their tech support or training materials to establish how to enter this information. Once this is done:

1.) Enter the insurance company, if not already entered
2.) Enter the Member/Insurance ID #
3.) Enter the group number (if it's on the card, not all insurance cards have this)
4.) Assign the insurance as primary (how this is done depends on the software
5.) Enter any secondary and tertiary insurance, if applicable

Entering Diagnosis codes:

1.) Get the diagnosis codes for the patient from the doctor
2.) Enter these in their appropriate place in the software
3.) CONDITIONAL: On Medicare claims, any M99 diagnosis must go in the <u>first</u> (primary) diagnosis position.

BILLING Rebels

Entering Charges:

1.) Get the charge information (fee slip) from the office.
2.) Enter the codes into the software
3.) Review all codes to ensure they are billed correctly, as per the coding guides and training data.

Sending Claims:

1.) Review the claims that are to be going out and correct any mistakes. (See claim guides below.)
2.) Approve claims (if needed depending on software)
3.) Send/upload electronic claims. (Sometimes this is done by the software and other times you need to actually log into the clearing house and upload the claims. Contact Tech support or the software training material for these steps.)
4.) If needed, print and send paper claims
5.) CONDITIONAL: You may need to align the paper claims to your printer. This ensures everything prints in the proper boxes and is properly aligned. This is a one time step. Contact tech support or the software training materials as needed.
6.) Confirm that the claims have been uploaded by the clearing house.
7.) Correct any rejected claims and resend them.

Claim guides:

Medicare: See Medicare billing training data. Electric Stim code is G0283 is used in place of 97014. (Note that Medicare now requires both Box 14 and Box 15 be filled out.)

United Healthcare: All physical therapy codes get a GP modifier, indicating it is a Physical Therapy service. Electric Stim code G0283 is used in place of 97014. XS is used in place of Modifier 59.

All other insurance companies follow the basic coding rules. See Chiropractic Coding Cheat Sheet, video “On Bunding and Modifiers 59, 25 and the X modifiers” on the ‘Advanced” tab and Coding Misconceptions in the google drive file.

If you have questions on proper billing of codes, post in the facebook group for assistance.
Entering EOBs

BILLING Rebels

Entering EOBs is the process of taking the data sent back by the insurance company on the EOB or ERA and entering it into the software so that the patient's account reflects what the EOB/ERA says.

You will first need to ensure you are trained on how the software program you are using enters EOBs and ERAs. Use their training material and tech support to accomplish this.

1. Is the EOB from the primary insurance or the secondary?
2. If secondary, has the primary ins EOB been entered? If not, enter that first.
3. Read the EOB and establish:
    - What amount is the insurance paying?
    - What amount is the patient responsible for?
    - What is the total allowed amount?
    - What is being written off?

    NOTE: If the EOB is from the primary insurance and the patient has a secondary, do not assign anything to the patient yet. All remaining balance is still insurance responsibility until the final insurance company has made their determination.

4. Enter this information into the software. The patient's account should now reflect the above data. If it does not, consult your software training material or their tech support to sort it out.

Non-payment EOBs:

There are two different categories of non-payments. The first is a non-payment due to patient responsibility. This is usually due to the patient still having a deductible that needs to be met before the insurance company starts paying. These should be entered into the software to reflect what the EOB/ERA shows.

The second category is a service that is not being paid due to a denial. These should only be entered into the software as they are shown on the EOB/ERA if the denial is totally unfixable. For example, prior authorization of the service was required but not obtained.

If the denial is fixable, do not enter the EOB. Instead fix the issue, resubmit the claim and wait for the new EOB/ERA to arrive.

NOTE: EOBs that come back denied and say “duplicate claim” mean that this claim was already submitted and an EOB already sent back. Do not enter the EOB that says “duplicate”, instead

locate the previous EOB and enter it. If that can not be found, call the insurance company and get the information on why it was denied or get the information on the payment previously made.